Typically, most of our folks can afford decent hamburger. So there will be no mass exodus of employers dropping health care coverage just because we are giving insurance companies some rules to live by.

Emergency care so that a person does not have to drive by the closest emergency room to get to the one that may be on their list, because frankly, we want to make sure they have the quickest and fastest emergency room care as possible.

Anti-gag. A physician or health care provider should be able to talk to their patients. They ought to be able to say, this is what your insurance company will pay for, this is what they will not pay for. Again, we have employers who can pay for the Cadillac plan and the Cadillac plan may pay for everything, but the Chevrolet plan may not pay for everything, but that doctor ought to be able to talk to their patients.

Open access to specialists for women and children, particularly chronically ill patients, so that every time they do not have to go back to their family practice person or their gatekeeper before they go to their oncologist, for example, if they are diagnosed with cancer. That should not have to be the case. Women ought to be able to use their OB-GYN as their primary care. Children ought to be able to go to a pediatrician without having to go back to a primary care doctor.

Of course, I talked about the external and binding appeals process and how important it is, and how important it is to have the accountability linked to that, that the accountability is hardly ever used if one has a real effective appeals process.

Those are the important things that managed care reform bill offers. I do not know, I heard we had 161 signatures, 167 now, so I would hope that we get to the 218. Of course, we are going to have to have it bipartisanly, and last session it was. We had some Republican Members who were supportive of the Dingell bill, and hopefully we will see them come together over the next few weeks so we can really see some national managed care reform, similar to what the States have been doing and doing so successfully.

I hear all the time that we do not want to in Washington tell States what to do. Well, I do not want to do that. But we can use the States as a laboratory, as an example, and say, okay, it is working in Texas, has been for 2 years. There is not a lot of lawsuits, there is not an increase in premiums. Actually, people are winning half of those cases.

I like to use the example that if I was a baseball player and had a 300 batting average, which is a 30 percent batting average, I would be making $8 million a year. But for my managed care provider, if they are only right half the time when they decide my health care, I want a better percentage than the flip of a coin.

In Texas, that is our experience. We have seen that we have the flip of the coin. We want a better percentage. Managed care providers I hope will see that percentage where they are not overturned, because they are actually providing better care and they are providing for more adequate care to their customers, our doctors, patients, and our constituents.

So that is why I think it is important. This year we need to have a real Patients' Bill of Rights. Last session we had one that was worse than a fig leaf, because it actually overturned laws that were passed by our State legislatures. So it would have hurt the State of Texas, the bill that passed this House last session by 5 votes. Thank goodness the Senate killed it. This year, hopefully we will have a real managed care and Patients' Bill of Rights.

I thank the gentleman for his leadership as our health care task force person on the Democratic side. We are doing the Lord's work in trying to do this.

Mr. PALLONE. Mr. Speaker, I thank the gentleman. I know our time has run out, but I think the gentleman said it well about using the Texas example to show how what we are proposing here works and has worked in Texas over the last two years.

EQUAL ACCESS FOR CHEMICAL DEPENDENCY TREATMENT

The SPEAKER pro tempore (Mr. DEAL of Georgia). Under the Speaker's announced policy of January 6, 1999, the gentleman from Minnesota (Mr. RAMSTAD) is recognized for 60 minutes as the designee of the majority leader.

Mr. RAMSTAD. Mr. Speaker, every day politicians talk about the goal of a drug-free America. Mr. Speaker, let us get real. We will never even come close to a drug-free America until we knock down the barriers to chemical dependency treatment for the 26 million Americans presently addicted to drugs and/or alcohol. That is right, Mr. Speaker. Twenty-six million American alcoholics and addicts today.

Mr. Speaker, 150,000 people in America died last year from drug and alcohol addiction. In economic terms, alcohol and drug addiction cost the American people $246 billion last year alone. That is with a B, $246 billion. American taxpayers paid over $150 billion for drug-related criminal and medical costs alone. That is more than the American taxpayers spent on education, transportation, agriculture, energy, space, and foreign aid combined; more than in all of those areas combined the American taxpayers spent for drug-related criminal and medical costs.

According to the Health Insurance Association of America, each delivery of a new baby that is complicated by chemical addiction results in an expenditure of $48,000 to $150,000 in maternity care, physician's fees, and hospital charges. We also know, Mr. Speaker, that 65 percent of emergency room visits are alcohol or drug-related.

The National Center on Addiction and Substance Abuse found that 80 percent of the 1.7 million men and women in prisons today in this country are there because of alcohol and/or drug addiction.

Another recent study showed, Mr. Speaker, that 85 percent of child abuse cases involve a parent who abuses drugs and/or alcohol; 85 percent of child abuse cases are related to alcohol and drug abuse. Seventy percent of all people arrested in this country test positive for drugs; two-thirds of all homicides are drug-related.

Mr. Speaker, I ask the question: how much evidence does Congress need that we have a national epidemic of addiction, an epidemic crying out for a solution that works; not more cheap political rhetoric, not more simplistic quick fixes that obviously are not working. Mr. Speaker, we must get to the route cause of addiction and treat it like any other disease.

The American Medical Association in 1956 told Congress and the American people that alcoholism and drug addiction are a disease that requires treatment to recover. Yet, today in America, only 2 percent of the 16 million alcoholics and addicts covered by health plans are able to receive adequate treatment; only 2 percent of those with insurance for chemical dependency treatment are able to get effective treatment.

That is because of discriminatory caps, artificially high deductibles and copayments, limited treatment stays, as well as other restrictions on chemical dependency treatment that are not there for other diseases. If we are really serious about reducing illegal drug use in America, we must address the disease of addiction by putting chemical dependency treatment on par with treatment for other diseases. Providing equal access to chemical dependency treatment is not only the prescribed medical approach, it is also the cost-effective thing to do; it is also the cost-effective approach.

We have all the empirical data, including actuarial studies, to prove that parity for chemical dependency treatment will save billions of dollars nationally, while not raising premiums more than one-half of 1 percent in the worst case scenario. It is well documented that every dollar spent for chemical dependency treatment saves $7 in health care costs, criminal justice costs, and lost productivity from job absenteeism, injuries, and subpar work performance. A number of studies have shown that health care costs alone are 100 percent higher for untreated alcoholics and addicts than for people who

have gone through treatment; 100 percent higher for those who go untreated.

Mr. Speaker, as a recovering alcoholic myself, I know firsthand the value of treatment, and as a grateful recovering alcoholic for 18 years, I am absolutely alarmed by the dwindling access to treatment for people who need it. In fact, over the last decade in America, 50 percent of the treatment beds for adults are gone. Even more alarming, 60 percent of the treatment beds for adolescents are gone.

Mr. Speaker, we must act now to reverse this alarming trend. We must act now to provide greater access to chemical dependency treatment.

That is why I have introduced the Harold Hughes, Bill Emerson Substance Abuse Treatment Parity Act named for two departed colleagues, one Democrat, one Republican, who did so much in this field of addiction; so much to raise public awareness, so much to help people in need, people who are suffering the ravages of drug and alcohol abuse. This is the same bill, Mr. Speaker, by the way, that last year had the broad bipartisan support of 95 House cosponsors.

This legislation would provide access to treatment by prohibiting discrimination against the disease of addiction. The bill prohibits discriminatory caps, prohibits higher deductibles and copayments that exist for treatment of other diseases. It also prohibits limited treatment stays and other restrictions on chemical dependency treatment that are different from other diseases. All we are saying, Mr. Speaker, is treat chemical addiction like other diseases.

Mr. Speaker, this is not another mandate. It does not require any health plan which does not already cover chemical dependency treatment to provide such coverage. It merely says that those which offer chemical dependency coverage cannot discriminate, cannot treat chemical dependency different from coverage for medical or surgical services for other diseases. In addition, the legislation waives the parity for substance abuse treatment if premiums increase by more than 1 percent, and it also exempts small businesses with 50 or fewer employees.

Mr. Speaker, it is truly the time to knock down the barriers to chemical dependency treatment. It is time to end discrimination against people with addiction. It is time to provide access to treatment, to deal with America's number 1 public health and public safety problem.

We can deal with this epidemic now or be forced to deal with it later. But, this problem, this epidemic will only get worse if we continue to allow discrimination against the disease of addiction.

As last year's television documentary by Bill Moyers pointed out, medical experts and treatment professionals agree that providing access to chemical dependency treatment is the only way to combat addiction in America.

We can build all the fences on our borders, we can build all of the prison cells that money can buy, we can hire thousands of new border guards, thousands of new drug enforcement officers, but simply dealing with the supply side of this problem will never solve it.

That is because, Mr. Speaker, our Nation's supply-side emphasis does not adequately attack the underlying problem. The problem is more than illegal drugs coming into our Nation, coming across our borders. The problem is more than that. The problem is the addiction that causes people to crave and demand those drugs.

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That is the problem, the addiction that causes people to crave drugs and to demand those drugs. So we need more than simply tough enforcement and interdiction. We need extensive education, and we need access to treatment.

Drug czar Barry McCaffrey understands. He said recently, and I am quoting, ''Chemical dependency treatment is more effective than cancer treatment, and it is cheaper.'' General McCaffrey also said, ''We need to redouble our efforts to ensure that quality treatment is available.'' Mr. Speaker, the director of our National Office of Drug Policy is right. All the studies back him up. Treatment does work, and treatment is cost-effective.

Last September the first national study of chemical dependency treatment results confirmed that illegal drug and alcohol use are substantially reduced following treatment. This study by the Substance Abuse and Mental Health Services Administration shows that treatment rebuilds lives, puts families back together, and restores substance abusers to productivity.

According to Dr. Ronald Smith, United States Navy Captain in the Medical Corps, and also Dr. Smith was formerly vice chairman of psychiatry at the National Naval Medical Center at Bethesda, Dr. Smith says ''The U.S. Navy substance abuse program works. It has an overall recovery rate of 75 percent.''

The Journal of the American Medical Association on April 15 of last year reported that a major review of more than 600 research articles and original data conclusively showed that addiction conforms to the common expectations for chronic illness, and addiction treatment has outcomes comparable to other chronic conditions, outcomes comparable to other chronic conditions.

The same study by the American Medical Association said that ''Relapse rates for treatment for drug and alcohol addiction are 40 percent,'' relapse rates. That compares favorably with those for three other chronic disorders: adult onset diabetes, 50 percent; hypertension, 30 percent; and adult asthma, 30 percent.

A March 1998 GAO report also surveyed the various studies on the effectiveness of chemical dependency treatment and concluded that treatment is effective and beneficial in the majority of cases. A number of State studies have also been done that showed treatment is cost-effective and good preventative medicine.

A Minnesota study, a study in my home State, Mr. Speaker, extensively evaluated the effectiveness of its treatment programs and found that Minnesota saves $22 million in annual health care costs because of our treatment programs, $22 million in the State of Minnesota alone saved because of treatment programs. A California study reported a 17 percent improvement in other health conditions following treatment, and dramatic decreases in hospitalization.

A New Jersey study by Rutgers University found that untreated alcoholics incur general health care costs 100 percent higher than those like me who have received treatment. So the cost savings and the effectiveness of chemical dependency treatment are well documented.

But putting the huge cost savings aside for a minute, Mr. Speaker, what will treatment parity cost? That is a question that is asked by a number of people. First, there is no cost to the Federal budget. Parity does not apply to the Federal Employees Health Benefit Plan, does not apply to Medicare or Medicaid.

According to a national research study that based projected costs on data from States which already have chemical dependency treatment parity, the average premium increase due to full parity it would be two-tenths of 1 percent, that is from a Mathematica Policy Research study in March of 1998, a two-tenths of 1 percent increase in premiums for policyholders.

A recently published Rand study by the Rand Corporation found that removing an annual limit of $10,000 a year on substance abuse care will increase insurance payments by 6 cents per member per year, 6 cents per member per year. Removing a limit of $1,000 increases payments by only $3.40 a year, or 29 cents a month.

The worst case scenario we could find, the study that showed the worst case scenario, estimated the cost would be five-tenths of 1 percent increase in premiums per month, which translates to 66 cents a month per insured.

So the bottom line, Mr. Speaker, for the cost of a cup of coffee per month we can treat 16 million Americans addicted to drugs and/or alcohol today, for the cost of a cup of coffee per

month to the 113 million Americans covered by health plans. At the same time, Mr. Speaker, the American people would realize $5.4 billion in cost savings from treatment parity, according to a recent California study.

So we could treat these 16 million American alcoholics and addicts who are addicted today, who are hooked today on alcohol and/or drugs. For the price of a cup of coffee we can treat 16 million Americans, and we can save in the process $5.4 billion to the American taxpayers.

United States companies that provide treatment have already achieved substantial savings. Chevron, for example, reports saving $10 for every $1 it spends on treatment. GPU saves $6 for every $1 spent. United Airlines reports a $17 return, a $17 return for every dollar spent on treatment by United Airlines.

Mr. Speaker, no dollar value can quantify the impact that greater access to treatment will have on people who are addicted and their families. No dollar value can measure the impact on spouses, children, other family members who have been affected by the ravages of addiction. Broken families, shattered lives, broken dreams, ruined careers, messed up kids, children on Ritalin, divorces, I could go on and on with the human impact of the ravages of this epidemic that has swept our Nation. How can we put a dollar cost on those horrible factors, those horrible results of addiction?

Mr. Speaker, this is not just another public policy issue. This is a life or death issue for 16 million Americans and their families, 16 million Americans who are chemically dependent covered by health insurance but unable to access treatment.

We know one thing for sure, Mr. Speaker. Treatment taught me that addiction, if not treated, is fatal. This is a fatal disease if not treated. Last year 95 House Members from both sides came together in a bipartisan way to support and cosponsor this substance abuse treatment parity legislation. This year let us knock down the barriers to treatment for 16 million Americans. This year let us do the right thing and the cost-effective thing and provide access to treatment. This year let us pass substance abuse treatment parity legislation to deal with the epidemic of addiction in America.

Mr. Speaker, the American people cannot afford to wait any longer. I urge all Members to cosponsor H.R. 1977, the Substance Abuse Treatment Parity Act of 1999. I ask my fellow recovering alcoholics and addicts, all 2 million of them, to write their Members of Congress, their Member of the House, their United States Senators, and urge them to cosponsor this treatment parity bill, H.R. 1977, the Substance Abuse Treatment Parity Act. That is H.R. 1977.

We need to mobilize the recovering community, we need to mobilize concerned people throughout America to pass this life and death legislation.

Finally, Mr. Speaker, I ask the loved ones of those still suffering the ravages of addiction and chemically dependent people themselves who are unable to access treatment to contact their United States Senators tomorrow, contact their United States representatives tomorrow, and urge them to cosponsor H.R. 1977, 1977, the Substance Abuse Treatment Parity Act.

Working together, Mr. Speaker, as Americans, as Members of Congress, working together we will knock down those barriers to treatment. We will provide access to treatment for those people suffering the ravages of addiction. We will, Mr. Speaker, get this done, but only only if the American people demand it. I hope and pray that the responses are there and that Congress wakes up to the need to deal with addiction, and this year passes the Substance Abuse Treatment Parity Act.

THE COMMUNITY REINVESTMENT ACT

The SPEAKER pro tempore (Mr. DEAL of Georgia). Under the Speaker's announced policy of January 6, 1999, the gentleman from Minnesota (Mr. VENTO) is recognized for 60 minutes.

Mr. VENTO. Mr. Speaker, I have taken this hour special order this evening to highlight an important law and an important policy that has existed since 1977 with regard to financial institutions, with regard to banking. It is called the Community Reinvestment Act.

What this law and policy that has been in place for these 22 years accomplishes is it requires that banks go through an examination of the nature of loans, not the nature but the place that they actually make credit available in their community.

Most banks, whether they are chartered by our national government or by our State governments, receive a franchise. They receive an area in which they can do business. Of course, those geographic areas have changed greatly as the nature of our economy and population has moved across the landscape of our Nation. But the fact is that they receive certain benefits from that franchise of banking.

One is, for instance, that they receive support from the license from the State or the national government to do a banking business which fundamentally means they can take in deposits and they can in fact loan out on a money multiplier basis multiples of what they actually have taken as deposits. In the event that they need dollars, the Federal Reserve Board has an open window that they can of course, on a short-term basis, borrow at very low-interest rates from.

Furthermore, of course, the deposits now that are within that institution, that are placed there by individuals from across the country, their savings, are in fact, of course, insured by the Federal deposit insurance corporation under a number of different programs.

So these are substantial benefits in terms of actually a license to be in the business. It sets up a relationship between our national government and State governments and the free marketplace. It has been very successful.

Our model of banking grows out of the egalitarian roots of the times of Thomas Jefferson, and of course there are many efforts during the first century of our Nation's existence in which banking did not work out as successfully as we would like, so coming to this model was very difficult.

Of course, as in the course of most economic activities, banking has changed greatly over the years. In 1977 it was apparent that credit needs were not being met in some of the local communities, whether they be urban communities or rural communities. So then Senator Bill Proxmire from Wisconsin in 1977 was able to enact something called the Community Reinvestment Act, which provides, as it were, an examination of meeting local credit needs of the community in which these banks exist, the geographic area, and of course in a practical sense the areas that they serve and which they draw deposits from especially.

Lo and behold, through many years that examination process developed. There is one thing that banks probably do not like and probably do not really think that they need and that is more regulations. To be candid about it, I think that the early laws and rules that tried to implement CRA did in fact present more regulations. I do not think there is any banker or any citizen, for that matter, that would like to see more regulatory burden.

But the fact was that over the years that has not been a hindrance. As this law has developed and has been serving our country, the fact is that the regulators have accomplished and streamlined many aspects of the Community Reinvestment Act.

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One of the most important legislative changes occurred in 1989 when then Congressman Joe Kennedy added an open disclosure provision to CRA; and since then, it has really, I think, taken off and come to significant attention in terms of the public.

As that has happened, there has been a new awareness and new impetus upon making this law even more effective than it was. There are a couple of factors that have influenced that. One is, increasingly, banks do not have as many deposits as other financial institutions that are nonbanks. It is estimated that in 1977, when this law was first passed, that about two-thirds of the savings and deposits existed in our